AMENDED IN SENATE JUNE 15, 1998

AMENDED IN SENATE MAY 27, 1998

AMENDED IN ASSEMBLY APRIL 16, 1998

CALIFORNIA LEGISLATURE—1997–98 REGULAR SESSION

ASSEMBLY BILL No. 2595

Introduced by Assembly Member Baugh

February 23, 1998

An act to amend Sections 10232.25, *10232.8,* and 10233.5 of the Insurance Code, relating to long-term care insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 2595, as amended, Baugh. Long-term care insurance.

Existing law regulates long-term care insurance. Federal law provides that long-term care insurance that meets certain requirements is subject to favorable income tax treatment. Existing law requires insurers that offer long-term care coverage to provide a notice comparing benefits under federally tax qualified policies and policies that meet California requirements but are not federally tax qualified.

This bill would revise the required notice.

Existing law provides for the certification of insureds as chronically ill individuals by health care practitioners for purposes of long-term care insurance.

This bill would provide that those provisions apply only to a policy or certificate intended to be a federally qualified long-term care insurance contract.

Existing law requires an outline of coverage to be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation, and requires that outline to include information regarding the toll-free telephone number of the Department of Insurance.

This bill would also require that outline to include information regarding the toll-free telephone number of the Health Insurance Counseling and Advocacy Program.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 10232.25 of the Insurance Code is amended to read:

~~10232.25. (a) Each insurer that offers long-term care coverage pursuant to Section 10232.2 shall make available at the time of a solicitation the following notice in a separate document, in 12-point type, to be signed and dated by the applicant and agent or insurer, with a copy provided to the applicant and the original maintained in accordance with paragraph (8) of subdivision (c) of Section 10508:~~

~~IMPORTANT NOTICE~~

~~THIS COMPANY OFFERS TWO TYPES OF LONG-TERM CARE POLICIES IN CALIFORNIA:~~

~~(1) LONG-TERM CARE POLICIES (OR CERTIFICATES) INTENDED TO QUALIFY FOR FEDERAL AND STATE OF CALIFORNIA TAX BENEFITS.~~

~~AND~~

~~(2) LONG-TERM CARE POLICIES (OR CERTIFICATES) THAT MEET CALIFORNIA STANDARDS AND ARE NOT INTENDED TO QUALIFY FOR FEDERAL OR STATE OF~~

~~CALIFORNIA TAX BENEFITS BUT WHICH MAY MAKE IT EASIER TO QUALIFY FOR BENEFITS.~~

~~INSERT TIP-IN TABLE HERE~~

~~(b) The notice required by subdivision (a) shall be made available by employers to employees and dependents who are offered by employers a choice of the two types of policies described and apply for coverage.~~

~~(c) The commissioner, after consulting with the Health Insurance Counseling and Advocacy Program, and after issuing a public notice and receiving public comments, may approve modifications to the language in the notice set forth in subdivision (a), if the modifications (1) are warranted based on federal or state laws, federal regulations, or other relevant federal decisions, and (2) are strictly limited to those necessary to ensure that the summary notice required by this section does not provide false or misleading information.~~

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SEC. 2. *Section 10232.8 of the Insurance Code is amended to read:*

10232.8. (a) In every long-term care policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits, the threshold establishing eligibility for home care benefits shall be at least as permissive as a provision that the insured will qualify if either one of two criteria are met:

(1) Impairment in two out of seven activities of daily living.

(2) Impairment of cognitive ability.

The policy or certificate may provide for lesser but not greater eligibility criteria. The commissioner, at his or her discretion, may approve other criteria or combinations of criteria to be substituted, if the insurer demonstrates that the interest of the insured is better served.

‘‘Activities of daily living’’ in every policy or certificate that is not intended to be a federally qualified long-term care insurance contract and provides home care benefits shall include eating, bathing, dressing, ambulating, transferring, toileting, and continence; ‘‘impairment’’ means that the insured needs human assistance, or needs continual substantial supervision; and ‘‘impairment of cognitive ability’’ means deterioration or loss of

intellectual capacity due to organic mental disease, including Alzheimer's disease or related illnesses, that requires continual supervision to protect oneself or others.

(b) In every long-term care policy approved or certificate issued after the effective date of the act adding this section, that is intended to be a federally qualified long-term care insurance contract as described in subdivision (a) of Section 10232.1, the threshold establishing eligibility for home care benefits shall provide that a chronically ill insured will qualify if either one of two criteria are met or if a third criterion, as provided by this subdivision, is met:

(1) Impairment in two out of six activities of daily living.

(2) Impairment of cognitive ability.

Other criteria shall be used in establishing eligibility for benefits if federal law or regulations allow other types of disability to be used applicable to eligibility for benefits under a long-term care insurance policy. If federal law or regulations allow other types of disability to be used, the commissioner shall promulgate emergency regulations to add such other criteria as a third threshold to establish eligibility for benefits. Insurers shall submit policies for approval within 60 days of the effective date of the regulations. With respect to policies previously approved, the department is authorized to review only the changes made to the policy. All new policies approved and certificates issued after the effective date of the regulation shall include the third criterion. No policy shall be sold that does not include the third criterion after one year beyond the effective date of the regulations. An insured meeting this third criterion shall be eligible for benefits regardless of whether the individual meets the impairment requirements in paragraph (1) or (2) regarding activities of daily living and cognitive ability.

(c) A licensed health care practitioner, independent of the insurer, shall certify that the insured meets the definition of ''chronically ill individual'' as defined under Public Law 104-191. In the event a health care

practitioner makes a determination, pursuant to this section, that an insured does not meet the definition of ''chronically ill individual,'' the insurer shall notify the insured that the insured shall be entitled to a second assessment by a licensed health care practitioner, upon request, who shall personally examine the insured. The requirement for a second assessment shall not apply if the initial assessment was performed by a practitioner who otherwise meets the requirements of this section and who personally examined the insured. The assessments conducted pursuant to this section shall be performed promptly with the certification completed as quickly as possible to ensure that an insured's benefits are not delayed. The written certification shall be renewed every 12 months. A licensed health care practitioner shall develop a written plan of care after personally examining the insured. The costs to have a licensed health care practitioner certify that an insured meets, or continues to meet, the definition of ''chronically ill individual,'' or to prepare written plans of care shall not count against the lifetime maximum of the policy or certificate. In order to be considered ''independent of the insurer,'' a licensed health care practitioner shall not be an employee of the insurer and shall not be compensated in any manner that is linked to the outcome of the certification. It is the intent of this ~~section~~ *subdivision* that the practitioner's assessments be unhindered by financial considerations. *This subdivision shall apply only to a policy or certificate intended to be a federally qualified long-term care insurance contract.*

(d) ''Activities of daily living'' in every policy or certificate intended to be a federally qualified long-term care insurance contract as provided by Public Law 104-191 shall include eating, bathing, dressing, transferring, toileting, and continence; ''impairment in activities of daily living'' means the insured needs ''substantial assistance'' either in the form of ''hands-on assistance'' or ''standby assistance,'' due to a loss of functional capacity to perform the activity; ''impairment of cognitive ability'' means the insured needs substantial

supervision due to severe cognitive impairment; ''licensed health care practitioner'' means a physician, registered nurse, licensed social worker, or other individual whom the Secretary of the United States Department of the Treasury may prescribe by regulation; and ''plan of care'' means a written description of the insured's needs and a specification of the type, frequency, and providers of all formal and informal long-term care services required by the insured, and the cost, if any.

(e) Until such time as these definitions may be superseded by federal law or regulation, the terms ''substantial assistance,'' ''hands-on assistance,'' ''standby assistance,'' ''severe cognitive impairment,'' and ''substantial supervision'' shall be defined according to the safe-harbor definitions contained in Internal Revenue Service Notice 97-31, issued May 6, 1997.

(f) The definitions of ''activities of daily living'' to be used in policies and certificates that are intended to be federally qualified long-term care insurance shall be the following until the time that these definitions may be superseded by federal law or regulations:

(1) Eating, which shall mean feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

(2) Bathing, which shall mean washing oneself by sponge bath or in either a tub or shower, including the act of getting into or out of a tub or shower.

(3) Continence, which shall mean the ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

(4) Dressing, which shall mean putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

(5) Toileting, which shall mean getting to and from the toilet, getting on or off the toilet, and performing associated personal hygiene.

(6) Transferring, which shall mean the ability to move into or out of bed, a chair or wheelchair.

The commissioner may approve the use of definitions of ''activities of daily living'' that differ from the verbatim definitions of this subdivision if these definitions would result in more policy or certificate holders qualifying for long-term care benefits than would occur by the use of the verbatim definitions of this subdivision. In addition, the following definitions may be used without the approval of the commissioner: (1) the verbatim definitions of eating, bathing, dressing, toileting, transferring, and continence in subdivision (g); or (2) the verbatim definitions of eating, bathing, dressing, toileting, and continence in this subdivision and a substitute, verbatim definition of ''transferring'' as follows: ''transferring,'' which shall mean the ability to move into and out of a bed, a chair, or wheelchair, or ability to walk or move around inside or outside the home, regardless of the use of a cane, crutches, or braces.

The definitions to be used in policies and certificates for impairment in activities of daily living, ''impairment in cognitive ability,'' and any third eligibility criterion adopted by regulation pursuant to subdivision (b), shall be the verbatim definitions of these benefit eligibility triggers allowed by federal regulations. In addition to the verbatim definitions, the commissioner may approve additional descriptive language to be added to the definitions, if the additional language is (1) warranted based on federal or state laws, federal or state regulations, or other relevant federal decision, and (2) strictly limited to that language which is necessary to ensure that the definitions required by this section are not misleading to the insured.

(g) The definitions of ''activities of daily living'' to be used verbatim in policies and certificates that are not intended to qualify for favorable tax treatment under Public Law 104-191 shall be the following:

(1) Eating, which shall mean reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.

(2) Bathing, which shall mean cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.

(3) Dressing, which shall mean putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.

(4) Toileting, which shall mean getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.

(5) Transferring, which shall mean moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

(6) Continence, which shall mean the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.

(7) Ambulating, which shall mean walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.

SEC. 3. Section 10233.5 of the Insurance Code is amended to read:

10233.5. (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(b) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(c) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(d) The outline of coverage shall be a freestanding document, using no smaller than 10-point type.

(e) The outline of coverage shall contain no material of an advertising nature.

(f) Use of the text and sequence of the text of the outline of coverage set forth in this section is mandatory, unless otherwise specifically indicated.

(g) Text which is capitalized or underscored in the outline of coverage may be emphasized by other means which provide prominence equivalent to capitalization or underscoring.

(h) The outline of coverage shall be in the following form:

‘‘(COMPANY NAME)

(ADDRESS—CITY AND STATE)

(TELEPHONE NUMBER)

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

(Policy Number or Group Master Policy and Certificate Number)

1. This policy is (an individual policy of insurance) ((a group policy) which was issued in the (indicate jurisdiction in which group policy was issued)).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this

coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) Provide a brief description of the right to return—''free look'' provision of the policy.

(b) Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) (For agents) Neither (insert company name) nor its agents represent Medicare, the federal government or any state government.

(b) (For direct response) (insert company name) is not representing Medicare, the federal government or any state government.

5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy (limitations) (waiting periods) and (coinsurance) requirements. (Modify this paragraph if the policy is not an indemnity policy.)

6. BENEFITS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductible(s), waiting periods, elimination periods, and benefit maximums.)

(b) (Institutional benefits, by skill level.)

(c) (Noninstitutional benefits, by skill level.)

(Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.)

7. LIMITATIONS AND EXCLUSIONS.

(Describe:

(a) Preexisting conditions.

(b) Noneligible facilities/provider.

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatments provided by a family member, etc.).

(d) Exclusions/exceptions.

(e) Limitations.)

(This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.)

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. (As applicable, indicate the following:

(a) That the benefit level will NOT increase over time.

(b) Any automatic benefit adjustment provisions.

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.)

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) Describe the policy renewability provisions.

(b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.

(c) Describe waiver of premium provisions or state that there are no such provisions.

(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which the premium may change.

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

(State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.)

11. PREMIUM.

(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.

12. ADDITIONAL FEATURES.

(a) Indicate if medical underwriting is used.

(b) Describe other important features.

13. INFORMATION AND COUNSELING. The California Department of Insurance has prepared a Consumer Guide to Long-Term Care Insurance. This guide can be obtained by calling the Department of Insurance toll-free telephone number. This number is 1-800-927-HELP. Additionally, the Health Insurance Counseling and Advocacy Program (HICAP) administered by the California Department of Aging,

provides long-term care insurance counseling to California senior citizens. Call the HICAP toll-free telephone number 1-800-434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California.

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